Link to Final Agency Decision
OAH 11-1800-18086-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Maltreatment Determination and Order to Forfeit a Fine for Wacosa Day Training & Habilitation	**FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION**

The above matter came on for hearing before Administrative Law Judge Barbara L. Neilson on October 11 and November 30, 2007, in Room 110 of the Stearns County Administration Center, 705 Courthouse Square, St. Cloud, Minnesota 56303. Both parties submitted post-hearing briefs. The OAH record remained open until January 31, 2008, for submission of reply briefs, but the parties notified the Administrative Law Judge that they had determined that reply briefs were unnecessary.

Theresa Meinholz Gray, Assistant Attorney General, appeared at the hearing on behalf of the Department of Human Services ("the Department" or "DHS"). Cara M. Hawkinson, Assistant Attorney General, was subsequently substituted as counsel for the Department. Thomas A. Janson, Attorney at Law, Schmitt & Janson Law Office, appeared on behalf of Wacosa Day Training & Habilitation.

STATEMENT OF ISSUES

1. Is Wacosa responsible for maltreatment by neglect of a vulnerable adult who choked while eating a meal at the Facility and subsequently died because it failed to adequately implement the vulnerable adult's risk management plan?

2. If so, did the Department properly assess a fine against Wacosa?

Based upon the files, records, and proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Wacosa Day Training & Habilitation ("Wacosa" or "the Facility") is licensed to provide day training and habilitation services for adults with developmental disabilities (referred to as "consumers") under Chapter 245B of the Minnesota Statutes. Wacosa serves approximately 300-400 consumers with

varying levels of mental and physical impairments at five different sites located in Sauk Centre and Waite Park, Minnesota.[1]

2. A Risk Management Assessment and Plan ("RMAP") relating to each consumer is developed by an Interdisciplinary Team which includes the person's case manager, family members, and representatives of the person's residential facility and work/day program. Others who have specific knowledge about risks to the consumer's safety may also participate in the development of RMAPs, such as physicians, nurses, and psychologists. RMAPs are reviewed at least annually and revised as needed.[2] The consumer's residential facility and work/day program are both responsible for following pertinent portions of the RMAP.[3]

3. As of November 2005, there were approximately 40 consumers at Wacosa's Waite Park South location. Wacosa client manager Matthew Nelson was responsible for training Wacosa staff members at that location about the consumers' RMAPs. He conducted weekly team meetings to highlight consumer issues that may have arisen over the course of the week. Wacosa staff members were required to read each consumer's RMAP annually and to document completion of this task.[4]

4. H.R.S. was a vulnerable adult who had been developmentally disabled since birth and suffered a severe traumatic brain injury in 1983. After the injury, he developed a seizure disorder. H.R.S. attended the work and day program at Wacosa - Waite Park South beginning in July 2003.[5] At the time relevant to this proceeding, H.R.S. was 57 years old and lived in a residential facility.[6] H.R.S. worked at Wacosa Monday through Friday from 1:30 p.m. to 7:30 p.m.[7] While at Wacosa, he typically assembled light bulb kits and scrapbook cover holders.[8]

5. H.R.S. had short-term memory impairment and frequently asked Wacosa staff if it was time to eat or time to go home as a means of relieving his anxiety about his memory problem.[9] The staff at H.R.S.'s residence found him to be obsessive about fluids and food. While at his residence, H.R.S. typically ate each meal too quickly, took bites that were too big, and wanted more to eat.

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[1] Testimony of Matthew Nelson.
[2] Testimony of M. Nelson; *see* Exs. 17A-17H. Ex. 17H is the same as Ex. 9.
[3] Testimony of M. Nelson, Michael Lawson, Jennifer Koll, and Mary Lieser.
[4] Testimony of M. Nelson.
[5] Testimony of M. Nelson; Exs. 16C at 1- 2 and 17D at 5-6. Prior to attending Wacosa's Waite Park South facility, H.R.S. lived with his mother and attended Wacosa's Sauk Centre facility from April to September 2002, and lived in an adult foster home and attended a day training program located in Long Prairie, Minnesota, from September 2002 to June 2003. *See* Exs. 16A and 16B.
[6] Ex. 17H; Testimony of M. Nelson and J. Koll.
[7] Testimony of M. Nelson.
[8] Testimony of M. Nelson; Ex. 20F.
[9] *Id*.; Testimony of M. Lawson, M. Nelson; Exs. 3 at DHS 61; 4 at DHS 67; 5 at DHS 74, 75.

H.R.S. frequently coughed a lot when he drank fluids too quickly. During the period from April 2003 to April 2006, H.R.S. choked twice while at his residence and staff needed to administer thrusts.[10]

6. Several Wacosa staff had observed H.R.S. eating too quickly and/or issued reminders to H.R.S. to slow down while eating prior to November 22, 2005.[11] Wacosa staff members had observed H.R.S. coughing while eating or drinking on at least two occasions in the past.[12] Mr. Nelson acknowledged that H.R.S. had a "potential to choke or eat too fast," and had problems with soft drinks "go[ing] down the wrong tube," but Mr. Nelson had never observed H.R.S. eating too quickly or taking bites that were too big.[13]

7. Wacosa staff never discussed H.R.S.'s risk of eating too quickly or taking too big bites at weekly staff meetings, or stated that he needed more supervision during lunch.[14]

8. The RMAP applicable to H.R.S. which was in effect from September 30, 2005, to September 30, 2006, stated under the category of chewing and swallowing that H.R.S. "may not always cut up his food; he may take too big of bites."[15] The RMAP set forth the following plan to address this issue: "staff remind [H.R.S.] to cut up his food and slow down when eating. [H.R.S.] will be given smaller forks when eating."[16] This RMAP contained a recommended day training and habilitation staffing ratio for H.R.S. of one staff member to eight consumers, required staff on the premises at all times, and allowed H.R.S. to be unsupervised for 5-10 minutes per day at home and zero minutes per day at work.[17] However, the RMAP also noted that H.R.S. "is able to stay alone for 10 minutes on back patio [at Wacosa] if he is not threatening to leave or is agitated."[18] Wacosa staff construed the latter provision to apply only to break times, and not to mealtimes.[19]

9. The meeting of the Interdisciplinary Team to draft the 2005-06 RMAP described above was held on September 21, 2005. H.R.S.'s Interdisciplinary Team consisted of Matthew Nelson from Wacosa; two employees of REM, H.R.S.'s residential placement facility; H.R.S.'s brother and legal guardian; and H.R.S.'s county case manager.[20] During the meeting, the

[10] Testimony of J. Koll.
[11] Testimony of M. Lawson; Ex. 2 at DHS 57(Donarski interview); Ex. 3 at DHS 62 (Lawson interview); Ex. 5 at DHS 76 (Schaefer interview); Ex. 6 at DHS 81 (Skogrand interview).
[12] Testimony of M. Nelson and M. Lawson; Ex. 3 at DHS 62.
[13] Testimony of M. Nelson; Ex. 4 at DHS 68, 69.
[14] Testimony of M. Nelson, M. Lawson.
[15] Ex. 17H at 5.
[16] *Id.*
[17] Ex. 17H at 12. The RMAP also stated that H.R.S. could not be unsupervised at all in the community, and that he was able to use the restroom independently in all settings.
[18] Ex. 17H at 4; Testimony of J. Koll.
[19] Testimony of M. Nelson.
[20] Ex. 17H at 13.

team discussed a current physician's restriction of H.R.S.'s fluid intake to 40 ounces per day. H.R.S.'s physician recommended this restriction because H.R.S. consumed a lot of water on a daily basis, which adversely affected his electrolytes and caused dizziness and unsteadiness. The issue of H.R.S. not cutting up his food and taking bites that were too large for him was identified at this meeting but not discussed in great detail. All of the team members agreed on the contents of the RMAP and signed off on it.[21]

10. Due to H.R.S.'s changes in residence and day treatment programs during 2002-2003, several RMAPs were issued for him during that time frame. RMAPs issued for H.R.S. prior to the September 2005-2006 RMAP also described his chewing and swallowing issue in identical fashion. The RMAPs issued after H.R.S. started attending Wacosa - Waite Park South in July 2003 consistently described the plan that should be followed to address that issue (staff reminders to cut up food and slow down when eating; giving H.R.S. smaller forks). The RMAPs issued prior to the time H.R.S. started attending Wacosa - Waite Park South in July 2003 set forth slightly different plans (reminders to cut up food, help with cutting up food, and encouragement to take smaller bites).[22]

11. The half-hour "lunch" break for Wacosa's second-shift group began at 4:30 p.m. each day. This group consisted of approximately fifteen consumers.[23] Wacosa staff members also took a lunch break during this time. Staff members were allowed to leave the Wacosa premises to pick up food from local restaurants, but they were required to return to Wacosa to eat their lunches within five to ten minutes.[24] The Facility did not specify a precise time by which staff members had to leave the premises to pick up lunch or return to eat it. At least one staff member would often attempt to leave the premises by 4:25 p.m. to pick up lunch. Other staff members brought their lunches to work with them. Generally three to five staff members supervised the second shift lunch break; the number depended on the day, the number of consumers, and which crews were working.[25]

12. At the time relevant to this proceeding, Wacosa client managers Matthew Nelson and Stephanie Schaefer typically conducted pre-lunch preparations each day beginning at approximately 4:15 p.m. Mr. Nelson and Ms. Schaefer distributed lunches to the consumers and heated food in the microwave

[21] Ex. 17H at 5, 13; Testimony of M. Nelson.
[22] *Compare* Ex. 17H at 5 *with* Exs. 17A at 4, 17B at 4, 17D at 4, 17E at 5, 17F at 5, and 17G at 6. The plan to address the issue set forth in Exs. 17A, 17B, and 17D (encompassing April 2002 through July 2003) is worded slightly differently than the plan set forth in Exs. 17E, 17F, 17G, and 17H (encompassing July 2003 through September 2006). Exs. 17A and 17B state, "WACOSA staff remind [H.R.S.] to cut up his food, help him cut up any food and encourage him to take smaller bites as needed." Ex. 17D states, "WACOSA and residential staff remind [H.R.S.] to cut up his food, help him cut up any food and encourage him to take smaller bites as needed."
[23] Testimony of M. Nelson.
[24] Testimony of M. Nelson; Ex. 6 at DHS 82.
[25] *Id.*

as requested by consumers.[26] For approximately the first five minutes of the lunch period, Mr. Nelson and Ms. Schaefer were either behind the blue counter (as pictured in the foreground of Ex. 22B) at one end of the lunchroom running the microwave for individual consumers or circulating around the room making certain the consumers had what they needed.[27] The remaining staff members in the lunchroom would sit down to eat their lunches and supervise the other consumers who were already eating. Staff members were not required to sit at the same tables with consumers during the relevant time period, although occasionally some of them did. Typically, staff members sat together at lunch and would eat and talk with each other during the meal while keeping an eye on the consumers.[28]

13. H.R.S. was frequently the first consumer from his group in the lunch room.[29] He usually brought a sandwich with deli meat or bologna and cheese that was prepared and cut in half for him at his residential facility, along with some fruit.[30] Although the food that came from H.R.S.'s home was usually ready for him to eat and Wacosa staff did not cut it up, staff was expected to take appropriate steps to cut up the food if necessary.[31] H.R.S. rarely, if ever, brought food that required a fork. He often wanted his sandwich warmed up in the microwave and he was generally the first in line and one of the first to sit down and start eating. H.R.S. typically sat near the exit door at the back of the room. Often, H.R.S. sat by himself at that table.[32] All of the staff members were responsible for supervising all of the consumers during lunch; no particular staff member was assigned to supervise H.R.S. H.R.S. was usually one of the first consumers to finish eating his lunch.[33]

14. On November 22, 2005, Matthew Nelson and Stephanie Schaefer began their lunch preparation at approximately 4:15 p.m. H.R.S. entered the lunchroom around 4:30 p.m.[34] On that day, H.R.S.'s lunch was a wrap/burrito with meat and cheese inside, rather than the usual sandwich. The wrap was not cut in half by the residential facility staff and Ms. Schaefer did not cut it up.[35] Ms. Schaefer distributed H.R.S.'s lunch to him, and H.R.S. sat down in his usual place at the back corner of the lunchroom by the exit door. The table at which H.R.S. was seated is pictured in the background of Ex. 22A, closest to the door. He sat in the black chair at the end of the table. H.R.S. was alone at the table when he began to eat just after 4:30 p.m. No one reminded him to eat slowly or cut up his food that day.

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[26] Testimony of M. Nelson; Ex. 5 at DHS 74.
[27] Testimony of M. Nelson.
[28] Testimony of M. Nelson and M. Lawson.
[29] *Id*.
[30] Ex. 4 at DHS 67; Ex. 5 at DHS 74.
[31] Exs. 3 at DHS 62, 4 at DHS 68, and 5 at DHS 74.
[32] Exs. 22A and 22B.
[33] Testimony of M. Nelson and M. Lawson.
[34] Testimony of M. Nelson.
[35] Ex. 5 at DHS 74.

15. The other consumers filed in and were assisted by Mr. Nelson and Ms. Schaefer near the blue counter. During this time, Wacosa staff members Nancy Donarski, Michael Lawson, and Christy Skogrand also entered the lunchroom.[36] Within a few minutes, Ms. Donarski, Mr. Lawson, and Ms. Skogrand were all seated together at a table near the table where H.R.S. was sitting by himself. The table at which staff members were seated is pictured in the foreground of Ex. 22A, and was perpendicular to the table at which H.R.S. was seated. Ms. Skogrand and Mr. Lawson sat in the black chairs, and Ms. Donarski sat in the pink chair across the table from them. Mr. Lawson and Ms. Skogrand had a clear view of H.R.S.[37]

16. At approximately 4:35 p.m., Mr. Lawson, Ms. Skogrand, and Ms. Donarski had all just begun eating when Mr. Lawson looked up and noticed that H.R.S. was choking.[38] H.R.S.'s face was blue and purple and his eyes were glazed over. Based upon his appearance, Mr. Lawson believed that H.R.S. had been choking for a while. Mr. Lawson jumped up, knocking over his chair, and ran to H.R.S. The commotion alerted the rest of the staff members to the situation. Mr. Lawson performed the Heimlich maneuver on H.R.S., who was still sitting upright in his chair. After three or four attempts to dislodge the food, H.R.S. slumped over. Ms. Donarski and Ms. Schaefer helped Mr. Lawson stand H.R.S. up while Mr. Lawson attempted some thrusts.[39] H.R.S. passed out and the staff members helped lay him on the floor. Ms. Skogrand then called 911 and Ms. Donarski obtained some latex gloves to perform a finger sweep of H.R.S.'s mouth. Mr. Nelson and possibly other staff members performed chest compressions on H.R.S.[40] The Waite Park Police arrived within minutes, followed by paramedics. The paramedics took over CPR, and then attempted to intubate H.R.S. His esophagus was blocked by a large amount of food, which the paramedic removed using forceps. The paramedics successfully intubated H.R.S. and transported him to the St. Cloud Hospital at approximately 5:00 p.m.[41] H.R.S. had a pulse when the paramedics transported him out of the Facility.

17. H.R.S. was admitted to the hospital with a diagnosis of choking and respiratory arrest.[42] He remained largely unresponsive during and after his intake examination by the physician. H.R.S.'s family arrived, including his brother and sister-in-law who were his legal guardians. They indicated that H.R.S. had a long-standing desire not to be resuscitated.[43] Based upon a Do Not Resuscitate – Do Not Intubate (DNR-DNI) order, H.R.S. was extubated and

[36] Testimony of M. Nelson and M. Lawson; Exs. 2, 3, 4, and 6.
[37] Testimony of M. Nelson and M. Lawson (making slight correction in the testimony of M. Nelson); Exs. 2 at DHS 59; 3 at DHS 65; 4 at DHS 70; 5 at DHS 77; 6 at DHS 83.
[38] Testimony of M. Lawson; Ex. 3 at DHS 62.
[39] Testimony of M. Lawson; Ex. 3 at DHS 62-63.
[40] Ex. 3 at DHS 63. Ex. 4 at DHS 68.
[41] Ex. 5 at DHS 76. Ex. 6 at DHS 81. Ex. 11 at DHS 9.
[42] Ex. 7 at DHS 105.
[43] Ex. 7 at DHS 104.

transferred to comfort measures only. H.R.S. passed away on November 24, 2005, at 10:25 p.m.[44]

18. There is no evidence that any Wacosa staff member reminded H.R.S. to cut up his food or slow down while he was eating on November 22, 2005.

Procedural Findings

19. The Facility completed a Vulnerable Adult Reporting Form and an Emergency/Incident Report regarding H.R.S. on November 22, 2005. The Department's Division of Licensing subsequently initiated a maltreatment investigation.[45]

20. Between December 9 and December 20, 2005, DHS investigators Lisa Antony-Thomas and Bob Cornelius interviewed Wacosa employees Nancy Donarski, Michael Lawson, Matthew Nelson, Stephanie Schaefer, and Christy Skogrand, as well as the brother and legal guardian of H.R.S.[46] A site visit was conducted by Ms. Antony-Thomas on December 20, 2005. The DHS investigators also reviewed the Facility's Vulnerable Adult Reporting Form and Emergency/Incident Report, both dated November 22, 2005; H.R.S.'s hospital records for November 22, 2005; and the RMAP applicable to H.R.S., effective September 30, 2005, to September 30, 2006.[47]

21. Mr. Cornelius prepared a memorandum dated March 20, 2006, that was reviewed and approved by Ms. Antony-Thomas and a unit supervisor.[48] The report concluded that "it was not determined as to whether or not neglect occurred," and included the following explanation:

> The RMP [of H.R.S.] documented that staff persons needed to remind [H.R.S.] to slow down and cut up his food, and the food was somewhat different than the usual sandwich. However, [H.R.S.] did not have a history of choking, so it was reasonable to believe [H.R.S.] could eat the burrito without cutting it up. Each staff person stated that they knew to remind [H.R.S.] to slow down and did so when needed, but did not say it was necessary that day. The five staff persons responded promptly and came to the aid of [H.R.S.]. Given that [H.R.S.] routinely brought a sandwich for his meal, and [H.R.S.] did not have a history of choking on a sandwich, there was not a preponderance of the evidence as to whether or

[44] Ex. 11 at DHS 9.
[45] Ex. 11 at DHS 8.
[46] Exs. 1-6.
[47] Ex. 11 at DHS 8-9.
[48] Testimony of L. Antony-Thomas.

not the facility staff persons failed to supply supervision that was reasonable and necessary during [H.R.S.'s] meal.[49]

22. By letter dated March 20, 2006, the Department informed the brother and legal guardian of H.R.S. that "[a]lthough the outcome was tragic, it was not determined whether or not staff persons failed to provide services that were reasonable and necessary for your brother on the date of his death." The letter informed the brother of his right to request reconsideration of the "inconclusive" determination. [50]

23. In a letter dated April 3, 2006, H.R.S.'s family timely requested reconsideration of the March 20 determination.[51] The family argued that "[b]ecause of his risk of choking, it is stated in [H.R.S.'s] Risk Management Plan that his food was to be cut up for him and that staff was to be present with him during meals to discourage him from taking big bites of food."[52]

24. Maura McNellis-Kubat, the Department's licensing section manager, and Jennifer Park, the licensing section's attorney, processed the request for reconsideration. Ms. Park questioned whether the "inconclusive" determination was consistent with other decisions made by the Department in the past.[53] Ms. McNellis-Kubat and Ms. Park discussed the case with Ms. Antony-Thomas. They concluded that the prior determination was overly focused on whether H.R.S. had a history of choking, and instead should look to whether reasonable and necessary supervision was provided so as to implement the RMAP as written.[54]

25. Prior to drafting a revised investigation memorandum, the Department reviewed the investigation record plus the letter dated April 3, 2006, in which the family of H.R.S. requested reconsideration. The Department did not conduct additional interviews or gather additional material.[55] Upon completion of its review, the Department issued a revised investigation memorandum on January 12, 2007, which superseded the memorandum dated March 20, 2006.[56]

26. The revised memorandum deleted the paragraph quoted in Finding No. 21 above, as well as its statement, "It was not determined as to whether or not neglect occurred . . . ." The revised memo substantiated neglect of H.R.S. by Wacosa and stated:

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[49] Ex. 11 at DHS 11.
[50] Ex. 12.
[51] Ex. 13.
[52] *Id.*
[53] Testimony of Maura McNellis-Kubat.
[54] *Id.*
[55] Testimony of L. Antony-Thomas.
[56] Ex. 14.

> [H.R.S.'s] RMP specified that staff persons were to "remind [H.R.S.] to cut up his food and slow down when eating." Facility staff persons did not sit at the same table as [H.R.S.] and did not directly supervise his meal; therefore, [H.R.S.'s] RMP was not implemented. There was a preponderance of the evidence that staff persons routinely allowed [H.R.S.] to eat at a table by himself and [H.R.S.] was placed at risk each time [he] ate a meal without being directly supervised. It was determined that neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which are not the result of an accident or therapeutic conduct).[57]
>
> The memorandum went on to state:
>
> It is not known whether the outcome for [H.R.S.] would have been different if a staff person had been sitting at the same table as [H.R.S.] to provide supervision and had reminded [him] to eat slowly. Although maltreatment was determined, it was not determined that [H.R.S.'s] death was a result of the maltreatment.[58]

27. The Department determined that Wacosa's conduct constituted maltreatment in the form of neglect against H.R.S. under Minn. Stat. §§ 626.557, subd. 9c(b), and 626.5572, subds. 15 and 17(a). The memorandum stated that, because it was common practice for H.R.S. to eat his meals by himself, the facility was responsible for maltreatment of H.R.S.[59]

28. On January 12, 2007, the Department ordered Wacosa to forfeit a fine in the amount of $1,000 under Minn. Stat. § 245A.07, subd. 3(c)(4), due to substantiated maltreatment by the license holder.[60] The Order informed Wacosa of its right to request reconsideration of the maltreatment determination and its right to request a contested case hearing. Wacosa timely requested reconsideration of the maltreatment determination as well as a contested case hearing.

29. On June 7, 2007, the Commissioner served a Notice and Order for Prehearing Conference for July 24, 2007. During the prehearing conference, the hearing was set to commence on October 11, 2007. The hearing was held as

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[57] Ex. 14 at DHS 5.
[58] *Id.*
[59] *Id.* The Department acknowledged at the hearing that it does not take issue with the CPR or first-aid training of any of the Wacosa staff members or with the staff-to-consumer ratio that was in place at Wacosa on November 22, 2005.
[60] Ex. 15.

scheduled and was completed in a second day of hearing on November 30, 2007.

30. A Protective Order was entered in this matter on June 22, 2007.

Based on the above Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Commissioner of Human Services and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50 and 245A.08.

2. The Department of Human Services gave proper and timely notice of the hearing in this matter.

3. The Department has complied with all procedural requirements of law and rule.

4. Pursuant to Minn. Stat. §§ 626.557, subd. 9d(f), and 245A.08, this is a consolidated contested case hearing on the maltreatment determination and the imposition of a fine.

5. Neglect of a vulnerable adult constitutes maltreatment.[61] Neglect is defined to mean the:

> failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is: (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and (2) which is not the result of an accident or therapeutic conduct.[62]

6. In determining whether the facility or an individual is the responsible party for substantiated maltreatment, Minn. Stat. § 626.557, subd. 9c(c) states that the following mitigating factors must be considered:

> (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive . . .;

[61] Minn. Stat. § 626.5572, subd. 15.
[62] Minn. Stat. § 626.5572, subd. 17(a).

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

7. The Department has proven by a preponderance of the evidence that Wacosa was responsible for maltreatment of H.R.S. by neglect because it failed to supply supervision that was reasonable and necessary to maintain H.R.S.'s health or safety by virtue of its failure to adequately train staff members regarding the need to remind H.R.S. to cut up his food and slow down when eating as required by his RMAP. This failure caused a substantial risk that H.R.S. could choke while eating.

8. Under Minn. Stat. § 245A.07, subd. 3(c)(4), the Department must assess a fine of $1,000 for each determination of maltreatment of a vulnerable adult under Minn. Stat. § 626.557.[63]

9. These Conclusions are reached for the reasons set forth in the Memorandum below, which is hereby incorporated by reference into these Conclusions.

[63] Minn. Stat. § 245A.07, subd. 3(c)(4).

Based upon the foregoing Conclusions, and for the reasons stated in the Memorandum attached hereto, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the Commissioner of Human Services:

(1) affirm the maltreatment determination against Wacosa Day Training & Habilitation; and

(2) affirm the order to forfeit a fine.

The Protective Order entered on June 22, 2007, shall remain in effect.

Dated: March 28, 2008

s/Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

Reported: Digitally recorded; no transcript prepared.

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. § 14.61, the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact the Appeals and Regulations Division, Department of Human Services, P.O. Box 64941, St. Paul, Minnesota 55164-0941, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

MEMORANDUM

This case involves a tragic situation and also presents a difficult question for determination. It is clear from the testimony provided at the hearing and the interviews summarized in the hearing record that the staff members at Wacosa enjoyed the company of H.R.S., cared a great deal about him, and did not intend to allow any harm to come to him. It is also evident that the staff members present in the lunch room on November 22, 2005 (Matthew Nelson, Michael Lawson, Nancy Donarski, Christy Skogrand, and Stephanie Schaefer) reacted quickly and appropriately once they became aware that H.R.S. was choking.

The issue of whether Wacosa neglected H.R.S. on the day in question is a difficult one. The RMAP applicable to H.R.S. which was in effect on November 22, 2005, noted that H.R.S. "may not always cut up his food; he may take too big of bites" and specified that, to address this issue, staff would "remind [H.R.S.] to cut up his food and slow down when eating" and give him smaller forks when eating. The RMAP did not explicitly state that H.R.S. had a risk of choking, nor did it require that staff sit with H.R.S. on a 1:1 basis during mealtime or maintain constant surveillance.

The Department argued that a preponderance of the evidence supports its determination that Wacosa neglected H.R.S. by failing to appropriately implement his RMAP by training its staff on the necessary level of supervision for H.R.S. while he was eating. The Department contended that, in order for supervision to be sufficient and consistent with the RMAP, Wacosa staff was required to remind H.R.S. to cut up his food and slow down when eating. For this to occur, the Department asserted that Wacosa staff needed to be situated in such a way that they could discern whether H.R.S. was eating too quickly or taking bites that were too large. According to the Department, the mere presence of staff members in the lunchroom was not sufficient to ensure that attention was being paid to H.R.S. to evaluate whether he was eating too quickly or taking bites that were too big. In addition, the Department suggested that it was common practice for the Facility to neglect H.R.S. through inadequate supervision.

Wacosa focused on the portion of the definition of neglect that requires supervision to be reasonable and necessary, "considering the physical and mental capacity or dysfunction of the vulnerable adult." Wacosa argued that the level of supervision required for a particular vulnerable adult is dependent upon that individual's abilities and disabilities. The Facility suggested that H.R.S. was sufficiently independent so as not to require the level of supervision implied by the Department. Wacosa also took issue with the Department's conclusion that "[b]ecause it was common practice for [H.R.S.] to eat his meals by himself, the facility staff was responsible for maltreatment." The Facility points out, correctly, that the RMAP that was in effect at that time did not require Wacosa staff to sit with H.R.S. while he was eating, nor did any prior RMAPs. Wacosa also relied

heavily on the fact that the RMAP did not explicitly state that H.R.S. had a risk of choking and argued extensively that H.R.S. did not in fact have such a risk.

After careful consideration of the entire record, the Administrative Law Judge has recommended that the Commissioner affirm the maltreatment determination and order to forfeit a fine. By emphasizing H.R.S.'s tendency not to cut up his food and take bites that were too big, the Judge finds that the RMAP provided fair warning of his risk of choking. To address this risk, the RMAP required staff (both at Wacosa and in his residence) to remind H.R.S. to cut up his food and slow down when eating. On November 22, 2005, Mr. Nelson and Mr. Lawson did not remind H.R.S. to cut up his food or slow down, nor was there any evidence that any other Wacosa staff member issued these reminders to H.R.S. Moreover, there was no evidence that Wacosa staff members were sufficiently observing H.R.S. to provide timely or routine reminders. This constitutes maltreatment by neglect under the definitions discussed above. Of course, as the DHS indicated in its final investigative memorandum, it is not possible to know whether or not the issuance of such reminders would have produced a different outcome and it cannot be said that H.R.S.'s death was a result of the maltreatment.[64]

The Administrative Law Judge reaches this conclusion despite the fact that the Department's final investigation memorandum and some of the testimony of its witnesses overstated the level of supervision that was required by H.R.S.'s RMAP. The Judge does not believe that it is fair to construe the RMAP to *require* that Wacosa staff sit with H.R.S. throughout every meal or constantly watch him as he ate. It would appear that the supervision contemplated by the RMAP could also have been satisfied by Wacosa staff being trained to pay particular attention to H.R.S. and issue general advisories to him to cut up his food and slow down as he ate. In any event, it is clear that the RMAP reflected a need for a greater level of supervision than was provided by the Facility on November 22, 2005, and that the Facility neglected to train staff to provide that supervision. Under the circumstances, the Facility was obliged to come up with a protocol that it would have its staff follow to ensure that H.R.S.'s RMAP would be adequately implemented. It failed to do so.

Of primary concern to the Administrative Law Judge is the fact that Wacosa staff did not consistently display an understanding of H.R.S.'s food-related issues and what approach they should be taking to address those issues.

[64] Ex. 14 at DHS 5. The Facility asserted that it was significant that the Annual Evaluation of Service Outcomes issued on September 14, 2005, regarding H.R.S. did not incorporate language from the 2004 report indicating that "he eats large amounts of food quickly." *Compare* Exs. 21 C *and* 21D. Ms. Kroll testified that she was unable to explain the omission of that language because H.R.S.'s tendency to eat large amounts of food quickly had not changed between 2004 and 2005. In any event, given the explicit and consistent identification of H.R.S.'s food-related risk contained in the RMAPs issued between 2003 and 2005, the failure of the 2005 Annual Evaluation to reference H.R.S.'s rapid eating does not warrant the assumption that rapid eating was no longer an issue for him.

For example, Matthew Nelson, who was responsible for training Wacosa staff regarding the RMAP of H.R.S. and other consumers, provided inconsistent statements regarding his own understanding of H.R.S.'s food-related risks even though he had worked with H.R.S. for approximately three years before he died and had participated in formulating the 2005 RMAP. In his hearing testimony, Mr. Nelson acknowledged that he understood choking to be a risk for H.R.S. based solely on the language of H.R.S.'s RMAP, but admitted that he had never inquired about this portion of the RMAP and said that he "didn't really notice a risk" for H.R.S. of choking.[65] Mr. Nelson also testified that he did not feel that any of the consumers in the lunchroom that day needed heightened supervision.[66] Other Wacosa employees were similarly vague about the requirements of H.R.S.'s RMAP. Ms. Donarski stated during her interview with the DHS investigator that she thought H.R.S. would know what food needed to be cut up and didn't appear to know that staff was to remind him to cut up his food.[67] Ms. Schaefer admitted that she did not know what H.R.S.'s RMAP said about how close staff needed to be to H.R.S. at meals.[68] And Mr. Lawson testified that he was not told anything in particular about H.R.S., and merely recalled being told by another staff member to "glance around and make sure everyone was okay" while the consumers were eating.[69]

Furthermore, there is no evidence that Mr. Nelson or anyone else from the Facility provided any information to staff members regarding what they should do to ensure that H.R.S. would not eat too fast or take bites that were too big. Wacosa did not introduce any evidence at the hearing documenting that its staff members had read H.R.S.'s RMAP or had received training regarding implementation of the RMAP, and offered no evidence that it monitored the adequacy of staff implementation efforts. In the two months that Mr. Lawson worked with H.R.S. before he died, Mr. Lawson recalls reminding H.R.S. only once to slow down when he saw H.R.S. eating too fast. Mr. Lawson remembered only one other instance in which another staff member told H.R.S. to eat more slowly, although Ms. Donarski, Ms. Schaefer, and Ms. Skogrand stated during their interviews with the DHS investigator that they had issued reminders to H.R.S. in the past to slow down while eating.[70]

The Administrative Law Judge cannot find on the basis of the evidence presented in this record that Wacosa staff had a pattern of neglecting H.R.S., as

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[65] Mr. Nelson told the DHS investigator during his interview in 2005 that there was a risk of H.R.S. eating too fast or choking. Mr. Nelson also expressed his understanding that it was only meat, like steak or pork chops, that needed to be cut up for H.R.S. by the Wacosa staff. Ex. 4 at 68.

[66] He noted that, in his view, only one of the individuals in the room - *not* H.R.S. - had a choking risk, and stated that Wacosa staff gave food to that consumer one portion at a time to diminish the risk.

[67] Ex. 2 at DHS 57.

[68] Ex. 5 at DHS 75.

[69] Testimony of M. Lawson.

[70] Testimony of M. Lawson; Ex. 2 at DHS 57 (Donarski); Ex. 3 at DHS 62 (Lawson); Ex. 5 at DHS 76 (Schaefer); Ex. 6 at DHS 81 (Skogrand).

argued by the Department. But it is clear that, on November 22, 2005, none of the Wacosa staff reminded H.R.S. to eat slowly, nor did they cut up H.R.S.'s burrito for him or remind him to do so. While there may have been five staff members present in the lunchroom while H.R.S. was eating, the evidence shows that none of those five individuals was observing H.R.S. very carefully. By the time Mr. Lawson saw H.R.S. choking, H.R.S.'s breathing had been restricted long enough that his face and lips had begun to turn a blue/purple color. Most of the staff indicated that they knew that H.R.S. was typically the first consumer in the lunchroom and often the first consumer to finish eating lunch. This should have been an indicator to watch H.R.S. more carefully during the early part of the lunch break. While it is possible that H.R.S. may have choked even if staff had been observing what he was eating and providing appropriate verbal cues, it is likely that his risk of choking would have been reduced if that level of supervision had occurred. It is appropriate to find that the Facility is the responsible party for the maltreatment due to the apparent inadequacy of its policies, procedures, and training to ensure adequate implementation of H.R.S.'s RMAP.

Based upon the record as a whole, it is recommended that the Department's finding of maltreatment and the fine levied against Wacosa be affirmed based upon its failure to implement H.R.S.'s RMAP.

B. L. N.